Mixed Migration Centre

MMC Asia 4Mi Snapshot – July 2020

The impacts of COVID-19 on Afghans in India and Indonesia: access to healthcare, livelihoods and support

Since April 2020, MMC Asia has been interviewing Afghan refugees and migrants in India and Indonesia to better understand their migration experiences and protection needs during the COVID-19 pandemic. This snapshot focuses on respondents' access to information and health care, as well as the economic and psychological impacts of COVID-19. It aims to contribute to an evidence base informing targeted responses on the ground, as well as advocacy efforts related to the challenges facing Afghans in India and Indonesia.

Recommendations

- Raise awareness of the potential asymptomatic nature of COVID-19 and provide clear messaging about access to health care and testing;
- Provide cash support, including to access healthcare services;
- Continue providing basic needs, sanitary items and psychosocial support to refugees and migrants in India and Indonesia;
- Support the longer-term access to livelihoods for Afghan refugees and migrants, including granting the right to work for refugees in Indonesia and facilitating access to income-generating activities in India;
- Facilitate the continuation of resettlement processes for Afghans in India and Indonesia.

Profiles

Information in this snapshot was collected from 18 April to 21 June 2020 in India (New Delhi), and in Indonesia (Jakarta and Bogor). 122 phone interviews were conducted in India and 142 in Indonesia. 38% of respondents in each country were women. All respondents had arrived in India or Indonesia during the past 24 months. 92% of respondents in Indonesia were under 40 years old, compared with 83% in India. Findings are representative only of the respondents and cannot be generalized to the wider Afghan population in each location.

Respondents are aware of COVID-19 and its symptoms, however gaps exist in both knowledge and practice

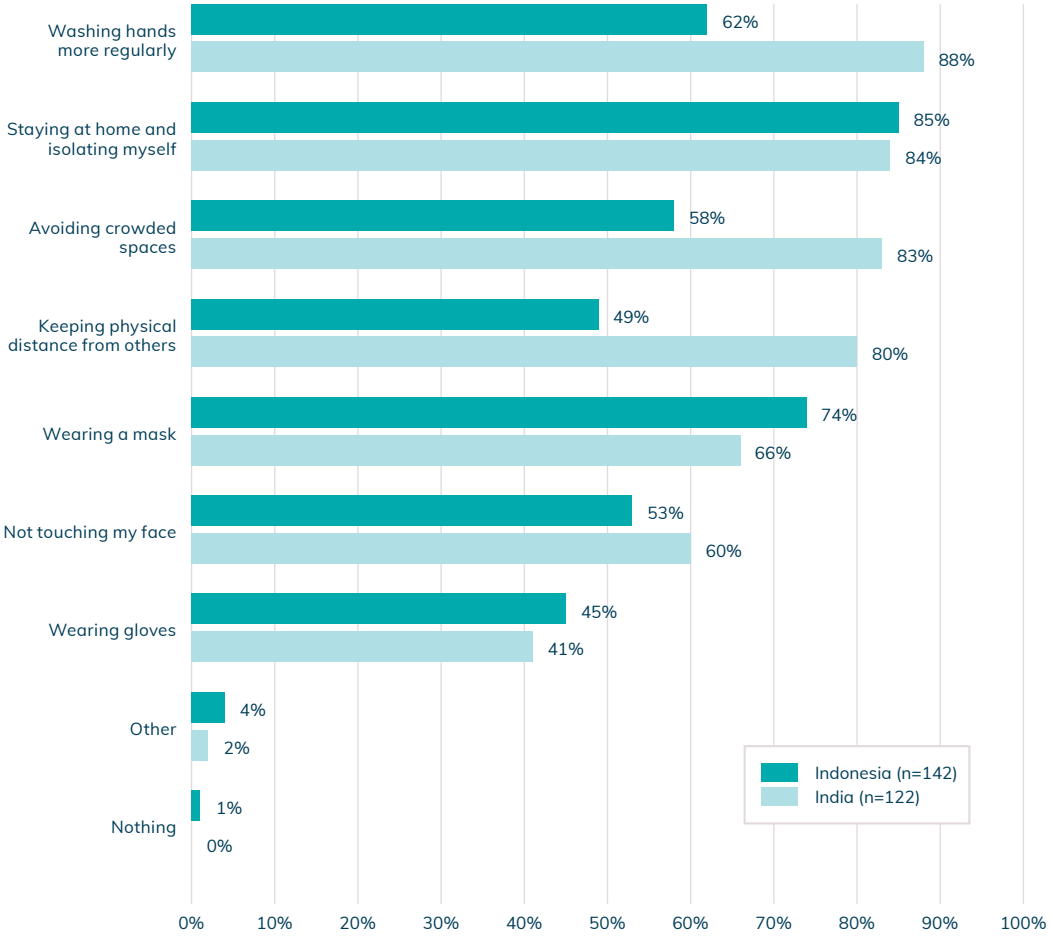
All respondents (n=264) reported that they had heard about COVID-19. Respondents also showed high levels of awareness about the symptoms of the virus, citing dry cough (98%), fever (89%), and difficulties in breathing (89%) as common symptoms, among others. However, only 17% of respondents in Indonesia (n=142) were aware that active infection may be asymptomatic. The proportion was higher in India, at 37% (n=122).

Most of those surveyed reported having practiced COVID-19 protective measures, with 92% and 95% of respondents in India and Indonesia, respectively, saying they know how to protect themselves from the virus. The most common protective measures practiced across both countries included staying at home and isolating from others (average 84%), and washing hands regularly or using hand sanitizer (average 74%), see Figure 1.

Key differences between the countries included a higher proportion of participants in India reporting they were keeping a physical distance from others (80% in India, compared with 49% in Indonesia) and avoiding crowded spaces (83% in India, compared with 58% in Indonesia). This is probably because of stricter lockdown measures in India, including the closure of public spaces, effectively enforcing higher levels of physical distancing.[1]

1 See https://www.nytimes.com/interactive/2020/world/asia/india-coronavirus-cases.html

Figure 1. What are you currently doing to prevent yourself against coronavirus?



In Indonesia, 22% of respondents said they could not practice the recommended physical distance of 1.5m in the place where they were living, higher than in India (13%). This figure increased to almost half among respondents living in reception centers (7 out of 16 responses), in line with reports of overcrowded living conditions in refugee shelters in Indonesia and posing an escalating risk of virus outbreak and transmission.[2]

> *"Every day is stressful here in Indonesia. I have spent nights sleeping on the streets before moving to a camp which is worse. There are no good memories here."*
> **27-year-old Afghan man, interviewed in Jakarta, Indonesia**

Barriers to accessing health services persist in both countries, although they are more prevalent in India

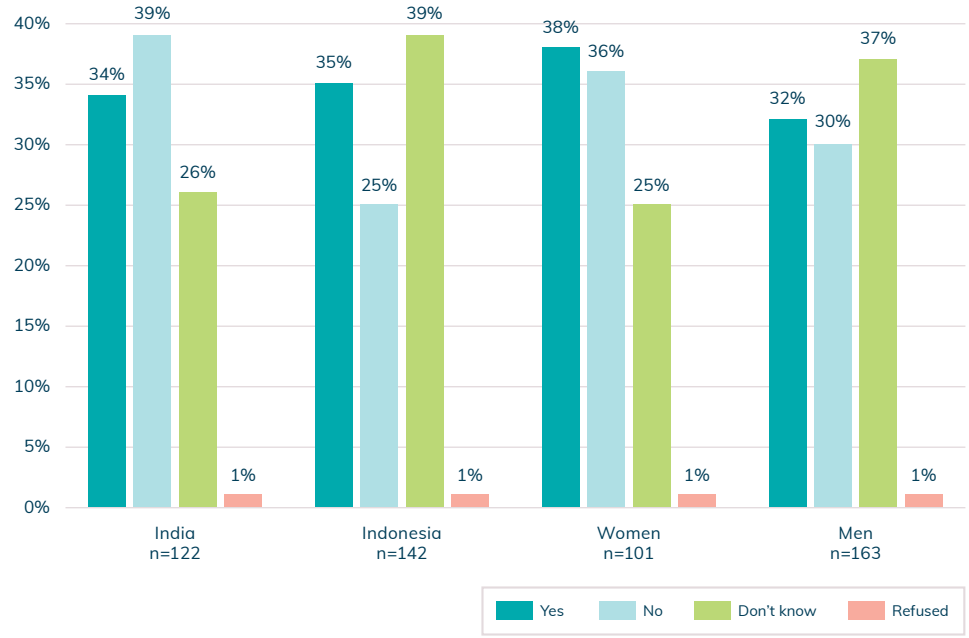
Only a third of the total respondents (n=264) said that if they had the virus symptoms, they would be able to access healthcare services right away, with a relatively even split across the two countries (35% in Indonesia and 34% in India), see Figure 2.

The inability to access health services is reported more often in India (39%) than in Indonesia (25%). It is also reported slightly more frequently among women (36%, n=101) than men (30%, n=163) across both countries.

Of all respondents, 39% in Indonesia and 26% in India said that they did not know whether they could access health services or not. This indicates a potential gap in information about how and where to access health services in both locations.

2 See https://jakartaglobe.id/opinion/a-call-for-help-refugees-risk-catching-covid19-in-overcrowded-shelters

Figure 2. If you had coronavirus symptoms and needed healthcare, would you be able to access healthcare services today?

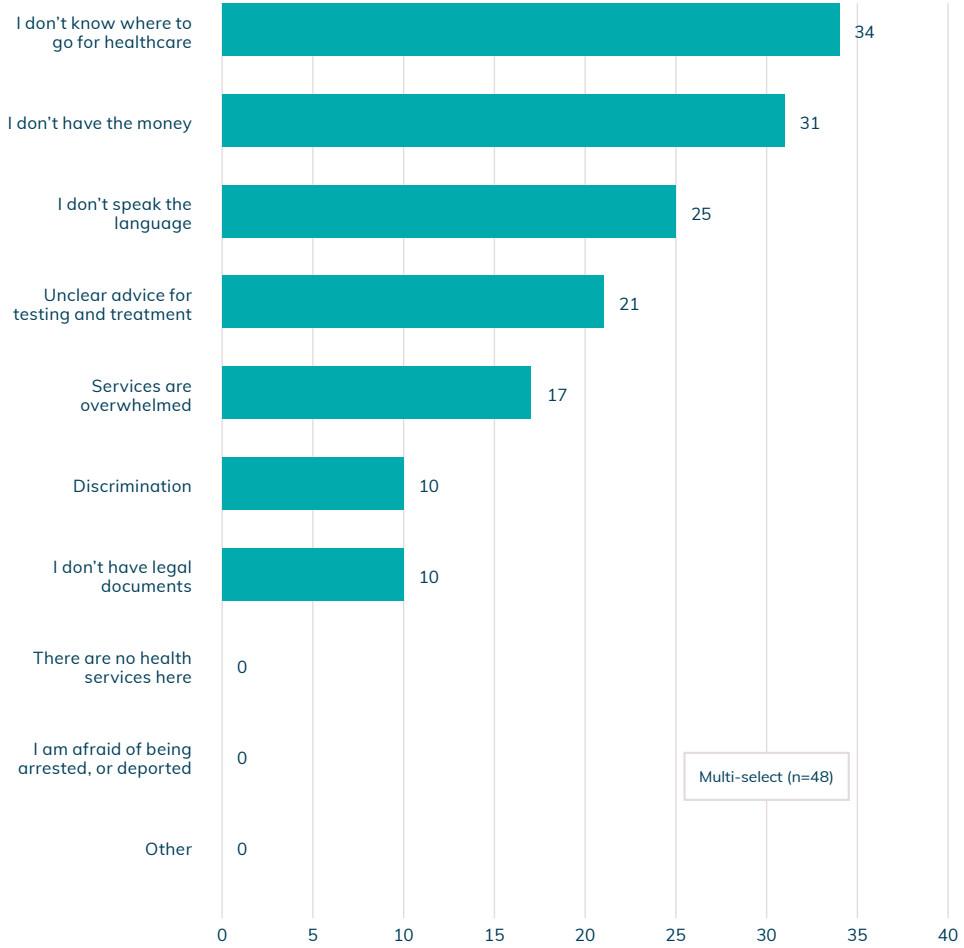


The most common barrier to accessing health services reported across both countries was the inability to afford health services (total 53 responses), see Figures 3 and 4. Overall more barriers were reported among respondents from India than Indonesia. In India, 34 respondents (n=48), reported not knowing where to go for health care, compared with 11 in Indonesia (n=36). Further, in India, 21 respondents said that the advice they received on COVID-19 testing and treatment was unclear, compared with only 4 in Indonesia. These findings indicate the need for more reliable information dissemination regarding health care and testing in India.

> *"Accessing medical facilities is not easy. We are borrowing money for medicine as we have no income or savings. It's hard for my family as my mother and brother are both sick."*
>
> **25-year-old Afghan woman, interviewed in Jakarta, Indonesia**

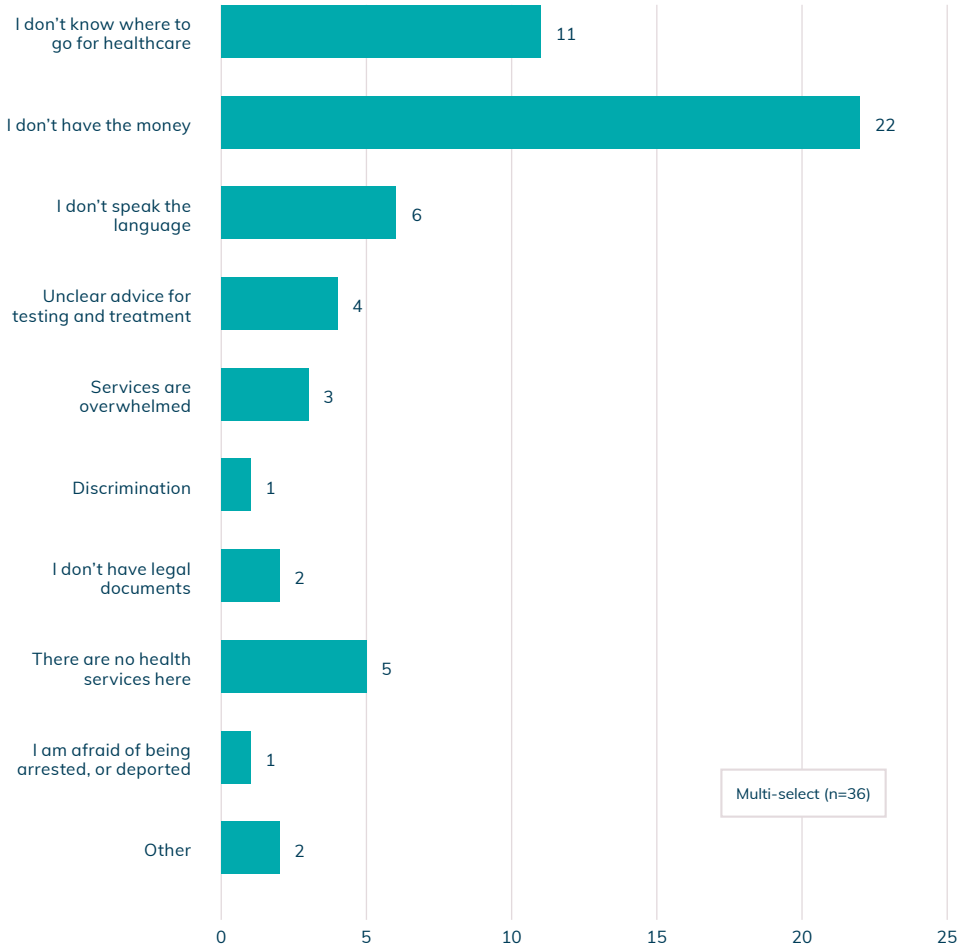
In addition, 17 respondents in India reported that overwhelmed services prevented them from accessing help, which may be a result of higher COVID-19 cases in India, especially in New Delhi.[3]

Figure 3. Barriers to accessing healthcare: India



3 See https://www.worldometers.info/coronavirus/country/india/

Figure 4. Barriers to accessing healthcare: Indonesia



Economic impacts of COVID-19 remain significant in India

70% of respondents in India reported losing income due to the COVID-19 situation, a slight decrease from the last update.[4] In Indonesia the lower proportion of respondents reporting income loss (11%) reflects the fact that the majority were not earning any income prior to the virus outbreak (89%), likely due to restricted work rights for refugees and reliance on aid for livelihoods.[5]

Among those who reported losing income (n=101, 85 in India and 16 in Indonesia), impacts included increased worry and anxiety (90%), inability to afford basic goods (57%), and inability to continue the migration journey (13%).

> *"Our main difficulty is paying our rent and electricity bills. I also have many other difficulties in supporting my family as I don't have any income because of COVID-19."*
> **53-year-old Afghan man, interviewed in New Delhi, India**

> *"All of us are facing financial problems and there is no one to help us. In addition, since the outbreak, discrimination against Afghans has increased in India and if we get sick with coronavirus, there is no one to help us."*
> **20-year-old Afghan woman, interviewed in New Delhi, India**

4 See http://www.mixedmigration.org/wp-content/uploads/2020/06/110_covid_snapshot_Asia.pdf
5 See https://theaseanpost.com/article/indonesias-refugees-need-sustainable-solutions#:~:text=On%20average%2C%20a%20refugee%20living,cannot%20generate%20their%20own%20income.

Psychological impacts of COVID-19 are high amid resettlement delays and job losses

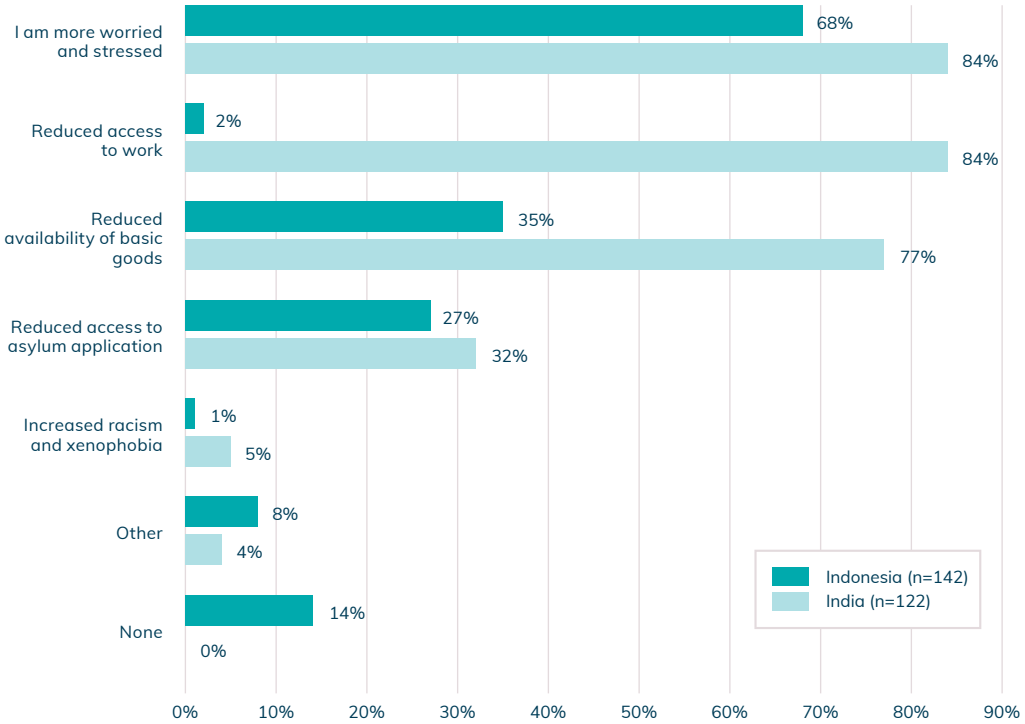
The most commonly reported impact of COVID-19 on day-to-day life across both countries is increased worry and stress (84% in India and 68% in Indonesia), consistent with the last update (see Figure 5).[6]

In addition, 32% and 27% of respondents in India and Indonesia respectively cited reduced access to asylum applications and processes. Delays in resettlement worldwide due to COVID-19[7] have caused concerns among refugee populations and are reported by some respondents in this survey.

> *"Since the outbreak, our life got more miserable here because there's no process of resettlement and we are getting more stressed. Our country (Afghanistan) isn't safe, and we cannot even go back there."*
> **30-year-old Afghan man, interviewed in Jakarta, Indonesia**

> *"I'm already depressed and scared of the virus. I don't know what is going on and what will happen in the future. I haven't got my refugee card yet and most of the time I'm thinking if I don't get my UNHCR card soon, what will happen to me."*
> **46-year-old Afghan woman, interviewed in New Delhi, India**

Figure 5. What impacts has the crisis had on your day-to-day life?



Other day-to-day impacts of COVID-19 reported by respondents differ significantly between the two countries. In India, 84% reported a reduction in access to work. Additionally, 77% cited reduced availability of basic goods, presumably because of job loss, coupled with soaring prices of essential goods in India.[8] In Indonesia on the other hand, reduced access to work was reported by only 2% of respondents, indicative of work restrictions mentioned previously. Also, 14% of Indonesians reported no day-to-day life impact of COVID-19, compared with 0% in India.

6 See http://www.mixedmigration.org/wp-content/uploads/2020/06/110_covid_snapshot_Asia.pdf
7 See https://www.thenewhumanitarian.org/news/2020/03/18/coronavirus-global-refugee-resettlement
8 See https://blogs.lse.ac.uk/southasia/2020/04/07/covid-19-and-rising-food-prices-in-india/

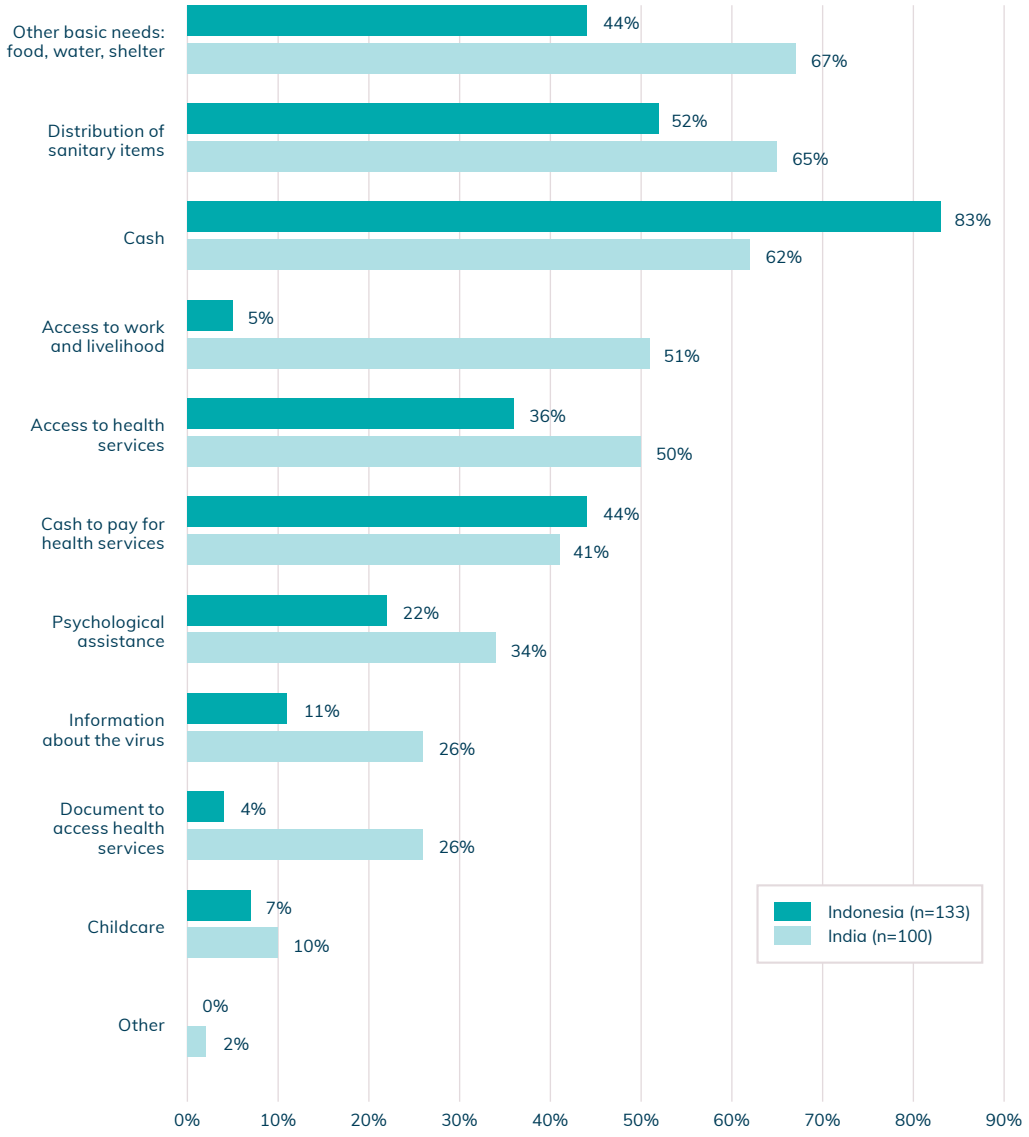
Persistent needs for cash support, sanitary items, and basic supports such as food, water and shelter

Since the last update in June 2020, the need for additional assistance has slightly decreased among respondents in India (from 86% to 82%) and slightly increased in Indonesia (from 88% to 94%). Across both countries, respondents cited cash as their major need (average 74%), followed by sanitary items (average 58%) and food, water and shelter (average 54%), see Figure 6.

Respondents in India cited the need for greater access to work and livelihoods (51%), which is in line with the high number of respondents reporting loss of income as a result of COVID-19, as discussed above. In Indonesia, cash, both for general purposes (83%) and to pay for health services (44%), was a more commonly reported need compared with India, likely indicative of larger issues relating to restrictions on work rights and the need for access to cash more broadly.

Despite the high reported needs among respondents, only 39% in India and 32% in Indonesia cited having received additional assistance since the pandemic began. In Indonesia (n=48), cash (35 responses) and sanitary items (25 responses) were the most commonly received relief items, compared with India (n=45), where basic needs, such as food, water and shelter (38 responses) were most commonly received.

Figure 6. What kind of extra help is needed?



4Mi & COVID-19

The Mixed Migration Monitoring Mechanism Initiative (4Mi) is the Mixed Migration Centre's flagship primary data collection system, an innovative approach that helps fill knowledge gaps, and inform policy and response regarding the nature of mixed migratory movements. Normally, the recruitment of respondents and interviews take place face-to-face. Due to the COVID-19 pandemic, face-to-face recruitment and data collection have been suspended in all countries.

MMC has responded to the COVID-19 crisis by changing the data it collects and the way it collects it. Respondents are recruited through a number of remote or third-party mechanisms; sampling is through a mixture of purposive and snowball approaches. A new survey focuses on the impact of COVID-19 on refugees and migrants, and the surveys are administered by telephone, by the 4Mi monitors in West Africa, East Africa, North Africa, Asia and Latin America. Findings derived from the surveyed sample should not be used to draw inferences about the total population of refugees and migrants, as the sample is not representative. The switch to remote recruitment and data collection results in additional potential bias and risks, which cannot be completely avoided. Further measures have been put in place to check and – to the extent possible – control for bias and to protect personal data. See more 4Mi analysis and details on methodology at www.mixedmigration.org/4mi